



Scope of Services – FSA Administration

Account Setup

1. Establish Administrative Procedures
2. Conduct Initial Implementation Meeting
 - Discuss business rules
 - Establish reporting requirements
 - Discuss special administrative requirements
 - Integrate Stored Value Card (if applicable)
 - Establish Auto-substantiation Methods for each benefit
 - Discuss card enhancements
 - Discuss funding methods, pre-fund amounts and banking relationship
 - Discuss receipt request process and timeframes
 - Configure card vendor system
3. Conduct weekly follow up meetings throughout implementation process
4. Draft Administrative Services Agreement
5. Customize Enrollment Form
6. Configure BC Administration System in accordance with business rules
7. Prepare Plan Document and SPD (optional service)
8. Program Data Interface(s) (if applicable)

Participant Data

1. Adds & Changes to Participant Elections (initial enrollment & ongoing)
 - Data may be transmitted in the following formats:
 - Paper Enrollment Form – Benefit Concepts form or client specific forms may be used
 - Excel Spreadsheet – Benefit Concepts will provide a template to ensure that all required fields are provided.
 - Electronic Data Feed – Data requirements and file specifications are typically established during the Implementation process but can be implemented at anytime.
 - All data received is processed within 72 hours of receipt.
2. Termination of Participant Elections
 - Termination records may be transmitted in the following formats:
 - Electronic Payroll Feed – Termination data received electronically must be sent on the payroll import file (see below for details regarding Payroll Feeds).
 - Excel Spreadsheet – Benefit Concepts will provide a template to ensure that all required fields are provided.
 - All terminations are applied to the system within 72 hours of receipt.
 - In the case of retroactive terminations, all claims paid after the termination date are marked as an 'Over Payment' and a letter is sent to the participant requesting reimbursement to the plan.

Payroll Data

1. Processing Payroll Deposits to Participant Accounts
 - Data may be transmitted in the following formats:
 - Electronic Payroll Feed

- Data requirements and file specifications are typically established during the Implementation process but can be implemented at anytime.
 - Exception report is generated and emailed to employer for review. The exception report lists deposit records that did not pass the deposit analysis process (i.e. Participant not in system, etc.)
 - System Generated Payroll – Benefit Concepts' Reimbursement Account system will auto-generate deposits based upon elected per-pay contributions. The employer must confirm deposit amounts using a Payroll Contribution Report (see Reports for more details).
2. All deposit Data is applied with in 72 hours of receipt or on the scheduled date of processing.
 3. Actual funds are held and maintained by the client. Benefit Concepts' deposit process is for monitoring balances.
 4. Benefit Concepts performs a reconciliation to verify that the total dollars expected for each deposit matches the total dollars posted to the Reimbursement Account System.

Reimbursement Account Claims Processing

Employers have the ability to choose between four (4) claim submittal processes. Multiple methods may be used unless otherwise noted.

1. Paper Claims Submittal
 - Participant submits claims using the Benefit Concepts' Paper Claim Form along with supporting documentation via mail or fax.
 - Supporting documentation must be received in an 8 ½" x 11" format.
 - Claims are processed once weekly based upon a predetermined processing schedule.
 - Data Entry of claims occurs as they are received.
 - Review of claims occurs on a predetermined weekly processing schedule.
 - Checks/ACH credits are created for claims that have been approved.
 - Funds are requested from Employer in the total amount of the checks/ACHs to be issued.
 - Checks are released and mailed upon confirmation of Employer funding.
2. Web Claim Submittal
 - Participant accesses Benefit Concepts Self Service Portal and keys in claim information.
 - Participants may submit claims and supporting documentation in one of two ways:
 - Print the transmittal form and submit the form along with supporting documentation via mail or fax. **Supporting documentation must be received in an 8 ½" x 11" format.
 - Electronically submit claims and supporting documentation via the Self Service Portal. Note: participant must have access to a desktop scanner to utilize this option.
 - Claims are processed once weekly based upon a predetermined processing schedule.
 - Checks/ACH credits are created for claims that have been approved.
 - Funds are requested from Employer in the total amount of the checks/ACHs to be issued
 - Checks are released and mailed upon confirmation of Employer funding.
3. Stored Value Card Submittal (Optional Service – 1)

Clients may opt for both Optional Service 1 & Optional Service 2; however participants may select only one of the options prior to participating

 - Sponsored by Evolution Benefits
 - Participants are issued Stored Value Cards.
 - Employer is required to establish a Collateral Bank Account with Bank Corp that is funded with a percentage of their Annual Contributions. This float must be maintained.
 - Participants may utilize the card at Health Care Related Merchants only.
 - Collateral Account replenishment occurs daily (ACH) or weekly (ACH or Wire).
 - Various auto-substantiation methods may be used to auto-substantiate claims. The options that can/will be used are determined by the options that are available to the employer:
 - IIAS (Inventory Information Approval System) – used in pharmacy, supermarkets and discount stores. Effective 1/1/2008, all supermarket and discount stores are required to have an IIAS system. Effective 07/01/2009, all pharmacies are required to have an IIAS system. If no IIAS system is in place, the Stored Value Card will be declined at the point-of-sale.

- Carrier Feeds – used for mail order pharmacy, medical, dental, and vision expenses.
 - Co-pay Analysis
 - Learned Logic
 - Card transactions that cannot be auto-substantiated require that the participant provide documentation to validate that the purchase is a qualifying purchase. Benefit Concepts sends notifications to the participants via mail. (See Communications section for details.)
 - Collateral Account True-Ups may occur at least once per-year. The float contained in the account will be adjusted based upon the Annual Election for the current population.
4. Carrier Roll-Over Submittal (Optional Service – 2)
- Clients may opt for both Optional Service 1 & Optional Service 2; however participants may select only one of the options prior to participating.*
- Benefit Concepts can receive files directly from the insurance carrier to use to substantiate and pay claims.
 - The data file may be sent in any format but must contain the necessary fields in order to process the transactions. A file specification call must occur between the Carrier and Benefit Concepts' EDI Department to define file specifications, testing schedule and file receipt frequency.
 - Benefit Concepts will process and reimburse the amount indicated as the employee's portion of the expense. The employee does not need to submit any forms or documentation.
 - Checks/ACH credits are created weekly for those claims that have been processed.
 - Funds are requested from the Employer in the total amount of the checks/ACHs to be issued
 - Checks are released and mailed upon confirmation of Employer funding.
 - Note: Some carriers may charge fees to produce and send the data file.

Communications to Participants

1. Generation and mailing of Participant Welcome Letter (optional service)
 - Letters are generated upon receipt of election information.
 - Letters outline the claims submittal process and reimbursement options and provide information about the Benefit Concepts Self Service Center. Note: The letter may not be edited.
2. Generation and mailing of Participant Statements
 - Statements are generated semi-annually. If required/requested more frequently, there are additional fees.
 - Statements show the current balance available and the total reimbursements made to date.
3. Generation and mailing of Check/ACH EOB's
 - All checks/ACHs that are generated weekly contain an EOB section listing the claims being reimbursed and account summary balances.
4. Generation and mailing of Request for Additional Information Letter (RFI Letter)
 - Request for Information Letters are generated for Paper and Web claims requiring additional substantiation to verify that an expense is qualifying.
 - Letters are generated daily for those claims that are marked as Suspended.
 - Participants have 52-days to respond with the additional information. If no response is provided, the claim is auto-denied and a Claim Denial Letter is sent.
5. Generation and mailing of Claim Denial Letter and Denial Insert
 - Claim Denial Letters and Inserts are generated for Paper and Web claims that are deemed non-qualifying.
 - Letters are generated daily for claims that are marked as Denied.
 - Participants have the right to appeal the denial in writing within the requisite timeframes measured from receipt of the notice.
6. Generation and mailing of Store Value Card Documentation Request Letters (Process is included in Claims Processing Optional Service 1.) Note: These letters may not be changed.
 - First Receipt Request – sent if a transaction cannot be auto-substantiated. Participant is given 20 days to respond with documentation. Note: 20 days is Benefit Concepts' standard; employers may select a different timeframe.
 - Second Receipt Request – sent if no response is received to the first request. Participant is given 20 days to respond with documentation. Note: 20 days is Benefit Concepts' standard; employers may select a different timeframe.

- Automatic Overpayment Request – sent if no response is received to the first two requests for documentation. Cards are placed in a temporary hold status until the participant responds with the necessary information or reimburses the plan for the expense.
- Ineligible Overpayment Request – sent if the participant responds with documentation that is insufficient to clear the transaction or documentation that lists the expense or a portion of the expense is non-qualifying. The transaction is marked as an overpayment and the participant is given 14 days to: (1) provide additional information, (2) submit manual claims to offset the overpayment or (3) send a check to reimburse the plan. Cards are temporarily placed in a hold status if no response is received within the 14 days and will remain on hold until the necessary information is provided or the plan has been reimbursed. Note: 14 days is Benefit Concepts' standard; employers may select a different timeframe.
- Reinstatement Letter – sent to participants once all overpayments have been cleared notifying them that their card has been reactivated.

Reports

1. Production and delivery of Check Listing Report
 - Lists all participants receiving a check/ACH as reimbursement for Paper, Web or Carrier submitted claims. Note: It is a standard report and may not be changed.
 - May be generated by location, if required
 - Generated and sent weekly via email based upon the claims processing schedule established during the Implementation process.
 - Employer is required to fund the total amount listed on the report. Once funds are received check/ACHs are mailed to the participant.
2. Production and delivery of Status Report
 - Lists detailed information about the participant's account balance (Per-Pay Contribution, Annual Contribution, Contributions to Date, Reimbursements to Date, and Available Balance). Note: This is a standard report and may not be changed.
 - May be generated by location, if required.
 - Produced in a Rich Text Format and sent via email to the employer during the first week of the month.
3. Production and delivery of Total Plan Report
 - Lists summary information about the plans' account balances (Number of Elections, the total posted contributions to date, the total claims paid to date, and the current available balance). Note: This is a standard report and may not be changed.
 - May be generated by location, if required.
 - Produced in a Rich Text Format and sent via email to the employer during the first week of the month.
4. Production and delivery of the Stored Value Overpayment Report
(*Process is included in Claims Processing Optional Service 1.*)
 - Lists any outstanding overpayments. Note: This is a standard report and may not be changed.
 - Generated in an Excel format and sent via email.
 - Provided to the employer upon completion of the run-off period.
 - The employer must either deduct the expense from the participant's salary or treat it as it would any other business indebtedness.
5. Production and delivery of the Payroll Contribution Report
 - Report is provided to the Employer prior to each payroll if the System Generated Payroll Deposit Method is selected. Note: This is a standard report and may not be changed.
 - May be generated by location, if required.
 - Adjustments must be noted on the report by the employer and returned to Benefit Concepts prior to the scheduled payroll processing date. Note: If the Payroll Contribution Report is not returned to Benefit Concepts by the payroll processing date, the deposit is processed based upon the expected per-payroll contribution and any adjustment that is received will be processed after the fact.

An Ad Hoc reporting tool is available for clients to create their own reports. There are no licensing requirements associated with this tool.

If Benefit Concepts is requested to create a non-standard report, the request will be reviewed and an estimated fee and completion date will be given to the client.

Communication with Plan Participants

1. Resolve Participant Claim Issues
2. Provide Toll Free Number of Plan Participants
3. Website Access to Account Balance & Claim Payment Information

Discrimination Testing under Section 129(d)(8) and 125(b) (Optional Service)